Hamburg Dentistry Office Policy Consent and Patient Disclosure Form

Hamburg Dentistry is HIPAA (Health Insurance Portability and Accountability Act) compliant and committed to meeting and exceeding the standards of infection control by OSHA, CDC and ADA

Your signature is necessary to process all insurance claims, authorize services, ensure payment for services rendered and acknowledges the following:

*I authorize dental services and am responsible for all charges, co-pays for myself, and family members, at time of service.

*Some insurance plans may not pay or reduce their benefit amount for specific procedures, in which case you will be financially responsible. **If you choose to proceed with a non-approved service or have out of network insurance, you agree you are financially responsible, and payment will be due at the time of service.**

*I understand this office reserves the right to verify credit status and may use one or more of the credit reporting agencies. In the event of financial default, I agree to pay collection and attorney's fees involved in the collection of any outstanding debt on your account.

*There is a $5.00 billing fee if a second statement is necessary, and a $35 returned check fee.

*Twenty-four-hour notice is required when cancelling an appointment. **We reserve the right to charge $75 when cancelling an appointment without 24 hours' notice.**

*If you do not complete, or do not return for future appointments for a case started, you will be responsible for lab fees, and appointment fees associated with the preparation of your case.

*After three missed appointments, we reserve the right to dismiss the family from Hamburg Dentistry.

*"I affirm the information given is correct and true to the best of my knowledge, and understand this information will be held in the strictest of confidence, and it is my responsibility to provide the doctors and staff with any updates in my medical, dental and personal information".

"I authorize the release of all medical/dental information necessary to process my claims and the release of this same information, when necessary, to other providers rendering dental or medical care. I assign all dental and medical benefits to which I am entitled to LOCFAM Dentistry, PC (dba) Hamburg Dentistry. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original". (12/2021)

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Signature **Date**

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Print Name